



Catholic University of Leuven - Institute of Social Law

**The Impact of the Crisis on Cash-for-Care Schemes  
for Dependent Elderly**

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**A Comparative study of France, Italy and England**

By

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*Older people are not a burden. They are just young people who got old.*

Anonymous older person

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## PREFACE

This paper is part of series of studies on the impact of the crisis on social security systems, tackled by students of the Master on European Social Security at the Catholic University of Leuven. The question we were assigned during the academic year 2009-2010 was the following:

*Europe and its states have been hit since Mid 2008 by a credit crunch, followed by a real financial and socio-economic crisis. Already before most European states were aware of the need to reform their social security systems in order to respond to the major challenges of the time, such as the demographic problem, the need to address new social risks etc. All kind of reform plans were put on the rails. What happened since mid 2008? Concretely, what was the evolution of the social security systems since 2000 and in what way was there a rupture in this evolution as a consequence of the crisis of 2008 and onwards? Did the international organizations and more specifically the EU change their advices to the countries since?*

This paper seeks to address only a limited range of these issues and is therefore focused upon cash benefits for care in three selected countries, namely France, Italy and England.

## ACKNOWLEDGEMENT

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## ABBREVIATIONS

ACTP	Allocation compensatrice pour tierce personne
ADF	Assemblée des Départements de France
ADL	Activities of daily living
AGGIR	Autonomie Gérontologique – groupes iso-ressources
ANCIEN	Assessing Needs of Care in European Nations
APA	Allocation Personnalisée d' Autonomie
ARS	Agences régionales de santé
ASISP	Analytical Support on the Socio-Economic Impact of Social Protection Reforms
CNSA	Caisse Nationale de Solidarité pour l'Autonomie
CSA	Contribution Solidarité Autonomie
CSCI	Commission for Social Care Inspection
CSG	Contribution sociale généralisée
DREES	Direction de la Recherche, des Études, de l'Évaluation et des Statistiques
EU	European Union
EU27	The 27 member states comprising the European Union
GDP	Gross domestic product
GEVA	Guide d' evaluation des besoins de compensation de la personne handicapée
IADL	Instrumental Activities of Daily Living
IB	Individual budgets
INPS	Istituto Nazionale della Previdenza Sociale
INSEE	Institut national de la statistique et des études économiques

ISSA	International Social Security Association
ISTAT	Istituto nazionale di statistica
LEP	Livelli Essenziali di Prestazioni
LTC	Long-term care
NCS	National Care Service
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
PCH	Prestation de compensation du handicap
PFLSS	Projet de loi de financement de la sécurité sociale
PSD	Préstation Spécifique Dépendance
UK	United Kingdom
US	United States

## GLOSSARY<sup>1</sup>

**Activities of daily living (ADL) :** a term used to describe self-care activities that a person must perform every day, such as eating, dressing, bathing, transferring between the bed and a chair, using the toilet, controlling bladder and bowel.

**Assessment :** The overall process for identifying and recording - the health and social care risks and needs of an individual and evaluating their impact on daily living and quality of life, so that appropriate action can be planned.

**Attendance allowance :** cash benefit provided to people in need of care, subject to an evaluation of dependency or care needs (distinguishing them from pension supplements), which may be used to pay for home care services, institutional care, or to pay or hire informal carers, depending on the benefit setting.

**Care :** Often used in the paper as synonym to long-term care.

**Care allowance:** cash benefit awarded to those providing care to the dependent older person. In England called *carer's allowance*.

**Carer :** the person providing care to the dependent older person. Also called *caregiver*.

**Care package :** services designed to meet an individual's assessed needs as part of the care plan arising from their assessment. Consists of one or more services, which may be residential and/or community-based. A cost is often attached if provided by social care, and hence needs to be approved by the budget holder; may also require contributions from the individual.

**Care plan :** personalised care plan details the high level, integrated health and social care requirements after a holistic assessment has taken place. Based on the summary of the risks and needs from the assessment, it should include details of the services to be provided, the assessed individual and their carer(s) participation, the objectives, a review date and consent from the assessed person to share the plan with the care team.

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<sup>1</sup> Source: OECD, 2005; Huber et al., 2009; Eurostat, 2009; UK Parliament; The NHS Care Records Service – Single Assessment Process, Glossary on Health, Social Care and Information Technology

**Care recipient** : the dependent older person in need of or receiving care.

**Care user** : see under *care recipient*.

**Case management** : when an individual has numerous long term conditions and complex needs, their care becomes more difficult for them to manage. Case Management is where a named coordinator actively manages and joins up care by offering, amongst others, continuity of care, coordination and a personalised care plan for vulnerable people most at risk.

**Community Care** : network of health and social care designed to enable an individual to remain independent and living in his or her own home. See also under *home care*.

**Cash-for-care** : cash benefits aiming to cover to cover expenses to purchase formal care at home or in an institution or to support informal care, allowing households choice over care decisions.

**Dependency** : condition when older people's overall level of functioning is substantially reduced, such that they are likely to require help from a third party, or substantial help from aids and adaptation, in order to fulfil the normal activities of daily life. In the paper used as synonym for the emerging social risk responding to the need of long-term care.

**Dependency ratio** : important demographic indicators that relate the young and old age population (those generally inactive) to the population of working age.

**Estate recovery** : procedure allowing to recover long-term care expenses from the estate of the care user after his or her death as a means to finance long-term care expenses.

**Formal care** : long-term care services supplied in some kind of contractual relationship (e.g. by the employees of an organisation or of the care recipient) in either the public or private sector, including care provided in institutions like nursing homes, as well as care provided to persons living at home by either professionally trained care assistants, such as nurses, or untrained care assistants.

**Home care** : care provided to care recipients living in their own houses or in ordinary apartments, including day care, respite care and direct support to individuals who provide care, such as care allowances and care leaves. In England referred to as *community care*.

**Informal care :** Care provided by informal caregivers such as spouses/partners, other members of the household and other relatives, friends, neighbours and others, usually but not necessarily with an already existing social relationship with the care recipient; usually provided in the home and typically unpaid.

**Institutional care :** long-term care services supplied or available 24 hours a day in institutions that also serve as a place of residency for those receiving care, with common areas of living for residents, even if they enjoy separate rooms. It does not include temporary or short-term stays, such as respite care.

**Instrumental Activities of Daily Living (IADL) :** activities that enable a person to live independently in a house or apartment, such as preparing meals, performing housework, taking drugs, going on errands, managing finances, using a telephone.

**Long-term care :** the organization and delivery of a broad range of services and assistance to people who are limited in their ability to function independently on a daily basis over an extended period of time. The services may be provided in a variety of settings including institutional, residential or home care.

**Local level :** for the purposes of this paper *local level* differentiates from the national level of governance and encompasses regions, municipalities, provinces and other authorities of public administration at a non-state level.

**Nursing care :** provision of care that includes assessment, treatment or care which can only be provided by or under the supervision by a registered nurse and extends to control of medication, dressing, injections, feeding requiring nursing skills, pressure sores, specialist incontinence management, complex prosthesis management and appliances, cognitive and behavioural support and management of complex psychological or aggressive states; but does not include any prescribed activity or extend to the provision of equipment by health authorities. In England it differentiates from ‘personal care’.

**Nursing home :** Care home that provides nursing care.

**Personal care :** (in England) provision of care that does not fall under the term nursing care and although its actual meaning depends from the appropriate care context it often

includes care relating to personal hygiene and toileting, assistance with feeding, eating and drinking, management of urinary and bowel functions, promotion of continence and management of incontinence, assistance with mobility and transfers, promotion of independence and social functioning, anxiety and behaviour management, social care needs assessment and ensuring personal safety, encouragement and assistance with cognitive functions, and administration and monitoring of medication.

**Residential home :** care home that does not provide nursing care.

**Social care:** services providing assistance with the normal activities of daily life, including personal functioning, domestic maintenance and social activities given on a continuing basis to individuals with chronic impairments and/or reduced degree of independence in IADL.

**Social services :** see under *social care*.

## **CHAPTER 1 – INTRODUCTION**

Although not a traditional social risk, dependency and the need for long-term care (LTC) have gained an important place in the social security arena: demographic ageing and changes in societal structures count among the main reasons for this shift.

The EU countries, acknowledging the importance of the LTC sector in the medium run, have engaged in debates on the trade-off between social insurance, private insurance and responsibilities of families, searching in particular for sustainable and affordable forms of financing the contingency of dependency.

The stress on long-term care provision faced by many European States was challenged once again due to the financial and economic crisis. This paper wishes to examine what was the impact of the crisis on long-term care schemes for older people. At a time when long-term care was already overstretched and underfunded how did EU States set their priorities? What happened to the planned reforms? Under which criteria did they cut down or continue with the policies already in place? Is there a common trend on how governments reacted under the economic pressure?

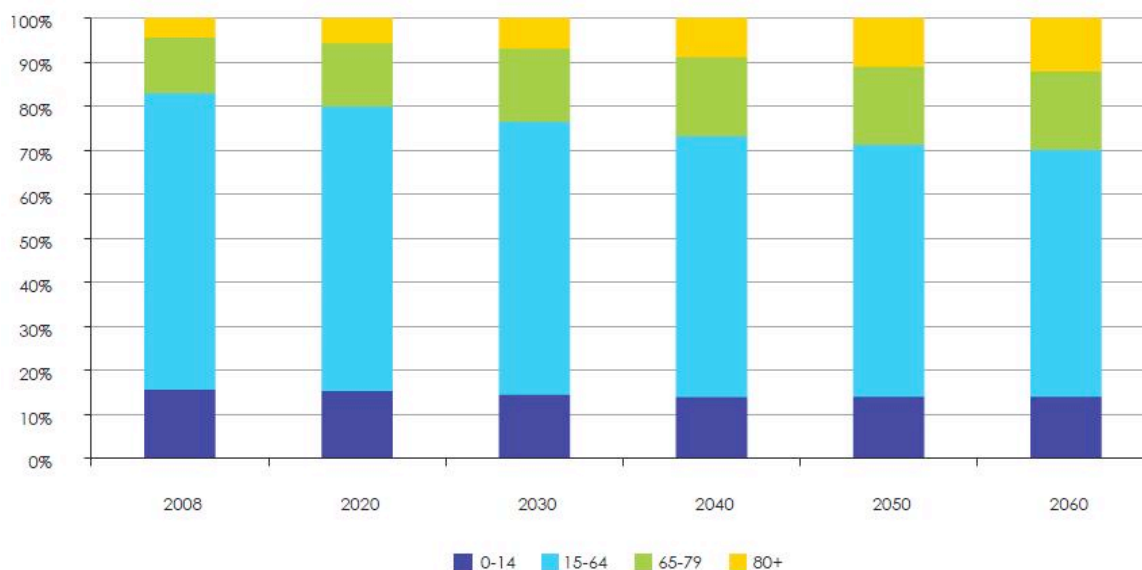
In this paper I will study the cash benefits for care in Italy, France and England, focusing on provisions for the frail elderly and their informal caregivers. First, I will briefly make reference to the common challenges faced by the European States, such as population ageing and decreasing family support. Second, I will try to demarcate the main concepts used in this study: long-term care; old age dependency and cash-for-care. Before moving to the main part of this paper, I will explain the methodology of my research.

### **1.1. Europe is getting older**

Numbers of people over 80 are expected to triple by 2060, representing the fastest growing segment of the population. (European Commission, 2008a) Three factors are linked to this demographic development: low fertility rates, increased life expectancy, and baby-boom generations that reach higher ages. (Eurostat, 2009) As frailty and illness increase with age, long-term care needs rise from 75 years onwards. (OECD, 2005) Therefore an ageing

population is accompanied by increased demand for long-term care and long-term care expenditure is expected to rise in the future.

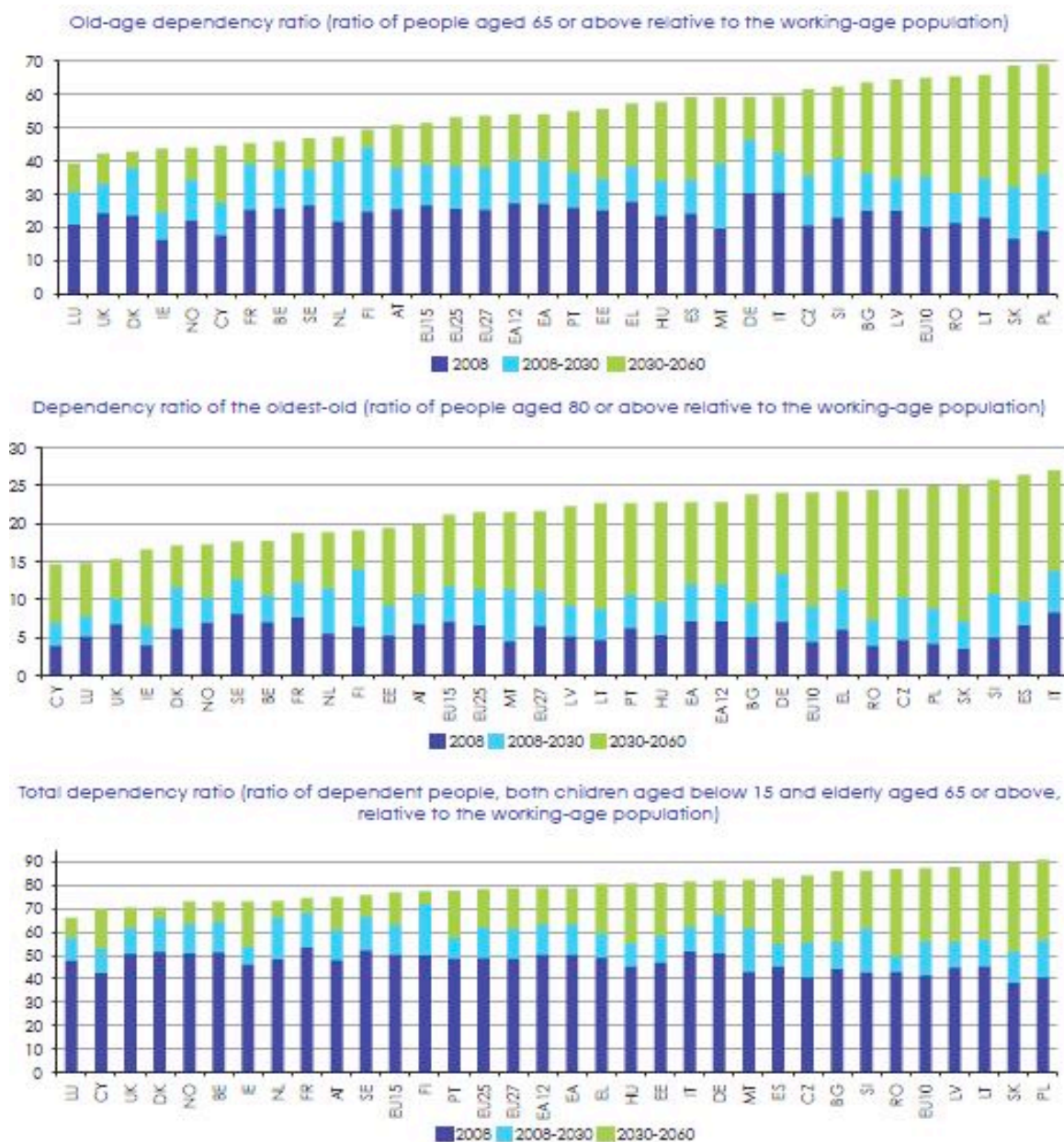
**Figure 1 – Projection of changes in the structure of the population by main age groups, EU 27 (in %)**



Source: EUROPOP2008, retrieved from Ageing Report 2009 (European Commission, 2008a)

Besides demographic evolution, changes in family arrangements, which limit considerably the availability of informal carers, place a higher burden on the public long-term care sector. Even in countries with a wide range of care services, informal care still remains the backbone of long-term care provision. Due to the greater participation of women in the labour market, the increased family mobility, the growing number of people living alone and the decreasing number of children per family, states may face escalating costs for long-term care. (Huber et al., 2009)

**Figure 2 – Dependency Ratios (in percentage)**



Source: EUROPOP2008, retrieved from Ageing Report 2009 (European Commission, 2008a)

The public long-term care sector will face serious difficulties in the medium and long term. Meeting the needs of an ageing population would mean providing a wide range of long-term care services both at home and in institutions and supporting informal and formal care. Currently, European states finance long-term care either within the existing systems of health and social insurance or by establishing new explicit schemes, as is the case for instance in Germany. (Pacolet et al, 2000) Moreover, introducing cash benefits play an increasingly important role in the attempt to address the risk of dependency. (Glendinning and Kemp, 2006) Against the backdrop of an ageing population, the organisation and funding of long-term care are often in the limelight, but it seems that until today dependency still remains an underinsured risk. (Pacolet et al., 2000)

## **1.2. Demarcating the research question**

Long-term care is widely perceived as a wide range of services addressed to people who because of advanced age and/or physical or mental conditions need assistance in performing everyday tasks. The OECD definition of long-term care (OECD, 2005) includes three main components: dependency over an extended period of life; link between causes of loss of autonomy (such as disability, chronic condition, illness etc) and dependency; limitation of ability to carry out activities of daily living (ADL)<sup>2</sup>. Although national terminology in this field may vary, for the purposes of this study, long-term care and dependency will be used as synonyms corresponding to the loss of autonomy in every daily living conditions. In fact, depending on national definitions long-term care schemes may be limited to social care or also include a part of the health care linked with (the cause of) dependency. In addition, it should be mentioned that some authors define dependency using socio-economical terms as well. (Pacolet et al., 2000)

Some examples could be useful to illustrate this complexity of definitions. The French word ‘soins de longue durée’ (literally long-term care) has a medical connotation corresponding more to the English word cure rather than care. Therefore in the social

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<sup>2</sup> Activities of Daily Living (ADL) for instance include: eating, bathing, dressing, going to the bathroom etc. (OECD, 2005)

policy field, the French use the words *'perte d'autonomie'* (loss of autonomy) or *'dépendance'* (dependency). For the French, the word dependency applies to older people, while the rest of the population facing a mental or physical incapacity are described as *'handicapés'* (handicapped), a word with a less negative connotation. Under French law the concept of dependency underlines the need to resort to the help of a third person in order to accomplish basic tasks. In English, on the other hand, the word *disability* is used for a condition of incapacity, while older people facing functional difficulties are qualified as *frail*. (Ylief et al, 2006) In Italy the notion of *non-autosufficienza* applies to non self-sufficient people regardless of their age. Although a consensus on what exactly this term refers to has not yet been reached, it seems that it is a wide concept encompassing social and health components, including difficulties faced by the individual in the private, social and working sphere. (ISTAT, Studio sulla tematica della “Non autosufficienza”)

Not only is long-term care at the boundaries between health and social care but in reality individuals cover their expenses related to the loss of autonomy in various ways. First, their income from old-age or invalidity pensions might be used to pay for a part of the related costs. Second, their health care insurance may cover a portion of the long-term care expenditure. In addition some services may be offered for free or at low cost, while some people may be entitled to additional benefits (for instance attendance allowances). As it was mentioned before, long-term care may also be an integral part of the social insurance system, in which case people regularly contribute as they do for their pension. Still a considerable part of long-term care expenses is covered by out-of pocket payments, while in some countries the private insurance market for this new risk is growing fast. For the scope of this paper I will look only at cash benefits that do not fall under the health care or social insurance (excluding therefore old age/retirement and invalidity pensions).

Delineating long-term care becomes even more complex depending on the setting in which care is provided (institutional and home care) as well as the relation between the caregiver and the recipient of care (formal and informal care). Although this paper will not look thoroughly into the significance of choosing between these forms of care, for reasons of completeness, these concepts are briefly explained in the glossary, while a visual

illustration of the different organizational forms and financing methods may be found in the matrix below.

**Figure 3 – Matrix of financing and organizing care of the elderly**

<b>Organisation</b>				<b>Financing</b>		
				<b>Informal sector</b>	<b>Formal sector</b>	
					<b>Private</b>	<b>Public</b>
<b>In cash</b>				Self help Mutual help (altruism & charity)	Insurance and savings (pay-as-you go or funded)	Transfers (social security, minimum income)
<b>In kind</b>	<b>Informal Care</b>			Self help (help by social network)	Paid voluntary work	Supported by the government
	<b>Formal professional care</b>	<b>Private</b>	<b>For-profit</b>	Sometimes even commercial organizers of charity market	Commercial firms on a private market	For-profit organizations on a subsidized market
			<b>Not-for-profit</b>	Private not-for-profit sponsored by charity	Own contributions	Subsidized private non-profit
		<b>Public</b>			Own contributions	Completely public financing

Source: Pacolet et al, 2000

Moreover, this paper focuses on older people. In this sense, unless long-term care provisions have no age limits, only the benefits relevant to older beneficiaries will be discussed. Definitions of older people may refer to a numeric age-limit above which one is considered an older person or may coincide with pension age. For this study, I will refer to the national conditions for entitlement for the care benefits, adopting therefore a flexible criterium for defining old age.

### 1.3. The role of cash-for-care

As already mentioned, long-term care is a relatively new social risk facing the challenge of increasing demand for care and decreasing supply of care. Although cash-for-care schemes may vary greatly, in general they aim at compensating costs related to dependency providing cash benefits “in-lieu“ of services in kind. They should therefore be distinguished from benefits seeking to replace income from work (i.e. disability or retirement pensions) Different types of cash benefits exist in the different European countries: attendance allowances for those in need of care that may be used with wide discretion by the care recipient; care allowances for informal carers as a means to compensate for the loss of income; strictly regulated personal budgets.

This study will focus on cash payments which are described in literature also as commodified care delivery systems or cash-for-care (Ungerson and Yeandle, 2007), therefore leaving out of the scope of the research indirect payments such as tax credits.

Ungerson has developed the term ‘commodification of care’ to indicate that direct cash transfers are part of a process of change in the support of care users and their caregivers, which enables care recipients to choose their own care. (Ungerson, 2003) According to Ungerson and Yeandle<sup>3</sup> cash-for-care schemes were developed in the 1990s influenced by the concepts of consumerism and marketization of the public services. Indeed it is believed that cash benefits allow care recipients to take control over care decisions and choose the most appropriate type of care depending on their needs. Besides enhancing the empowerment of the individual, the authors argue that cash-for-care is inevitably linked with state concerns about cost containment. Cash subventions function as incentives for care provided in the household of the care user which is more affordable (both for the state and the individuals) than institutional care. Moreover, they encourage care provided by relatives in an informal setting which not only enlarges the pool of available carers but also delivers care at a relatively lower cost than formal care. Meanwhile, cash benefits may underpin intragenerational and intergenerational solidarity allowing relatives to take care of

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<sup>3</sup> Ungerson and Yeandle, 2007

each other, which might be impossible in case of no income support. In addition, for Ungerson and Yeandle direct payments equally reduce employment, organizational and risk management costs for the states, which are passed on to the individual. Under this individualistic approach, there is a state recognition of the value of citizenship and a kind of partnership between welfare state, care recipients and caregivers is developed<sup>4</sup>. Last, the authors recognize another important factor in the development of cash-for-care; the disability movement as well as the politics of old age have played a significant role in lobbying for increased autonomy in empowering care users and promoting the rights of these two groups.

Although these considerations reflect perfectly the situation in some countries, like the United Kingdom (UK), in other cases, as in France, the introduction of cash benefits in the care sector was more associated with the professionalization of long-term care rather than encouraging informal provision. (Martin and Le Bihan, 2007) Therefore an important distinction ought to be made: whether the care recipients may use the cash benefit to purchase care in the formal sector only or they are also permitted to employ informal carers (even if they are coming from their family environment) is crucial both for the care relationship and the sustainability of the system as professional care is in general more expensive than the one provided within the household of the care user. Moreover, as it will be demonstrated below, the level of regulation of the use of the cash benefit may have an

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<sup>4</sup> For more information on this issue see Ungerson, Clare (2003) '*Commodified care work in European Labour Markets*', *European Societies*, Vol: 5, No: 4, pp. 377 — 396, where the author explains: "*If care users are funded to employ their own care directly, this demonstrates a form of trust by the state that its citizens know best as to how to resolve their own needs (in much the same way as most welfare states – but noticeably not the USA welfare system laced, as it is, with food stamps – trust their citizens to spend their benefits in the way they think best). At the same time, if care users are given carte blanche to employ whoever they want – and, as we shall see, many welfare states do precisely this – then, should care users choose to pay their relatives who care for them, such payments to care constitute a recognition of the care that informal carers deliver and provides them, very directly, with a sense of the presence of the state in the care relationship. Thus the notion of a partnership between welfare state and its caring citizens and its citizen care users is, at least notionally, developed*"

impact on the quality of care as well as to the development of a grey labour market.

Whereas giving the care users the possibility to choose their own care may improve the care delivery since it allows a larger flexibility to deal with conditions that may be difficult covered by formal services, it does not come without negative implications.

Providing direct payments to support informal care or purchase it in the formal market does not necessarily mean that the generosity of the benefits covers the actual value of the care involved; either the care user is obliged to finance the additional services through out-of-pocket payments or the informal carers do not receive a subvention corresponding to the actual work they undertake. As a result, instead of efficiently supporting care delivery, cash payments may contribute to promoting low paid labour with minimum social rights. (Glendinning and Kemp, 2006) These precarious working conditions prove unable to upskill and change the image of the carer profession.

The aftermath of allowing the users to choose the type of care by providing them with cash subventions, is that it is more difficult to control the quality of the delivered care. In case long-term care is ensured through public care services, (normally) certain quality standards have to be met. When beneficiaries are completely free to decide on who they employ as a caregiver, monitoring whether care meets the individual's needs is a lot more complex, especially when care is delivered within the household of the older person. Although it is generally believed that home care may be able to respond better to personal needs and expectations it does not necessarily guarantee that care in an informal setting is of a better quality. As most informal carers receive little or no training the risk of inappropriate care is not absent especially under policy frameworks lacking any regulation of how the payment is used. This is the case in Italy, where as a result of the absence of regulation a significant part of long-term care is delivered by irregular migrants.

To address this challenge, promoting professional care and introducing case management becomes a part of the policy stance. (Ungerson and Yeandle, 2007) The debate on who will make the care decisions and whether older people are at risk of exploitation and abuse is in the center of public debate in the UK. (Washington, 2009) But, in the bottom line such

policies are less affordable than informal care provision.

This consideration unpicks the complexity of care policies as analyzed by Ungerson and Yeandle. The editors of the book *Cash for Care in Developed Welfare States* reveal a risk of bipolarization of state policies on care arising from decisions which aim, on the one hand to support informal care as a means to contain costs and on the other hand to promote care work in the formal economy which would improve the status of the care worker and possibly the quality of care but would also increase expenditure.

#### **1.4. Methodology**

In order to tackle my research question, I decided to examine three welfare states (France, Italy and England) who do not (yet) have a separate social insurance for the risk of dependency. The idea was to see not only how the crisis has affected cash allowances but also to find out whether there has been an evolution in the debate about the financing and organization of LTC in general and towards which direction. It was under this spectrum that I decided to narrow down my research and instead of studying the whole of the UK which would mean looking into four different LTC systems to focus on England who was undergoing some interesting developments at the moment that this paper was drafted.

While France, and Italy are Bismarck-oriented states and the UK Beveridge-oriented, the three selected countries bear some similarities: first, family plays a central role in financing and contributing in LTC provision; the state not only plans LTC policy but also contributes through general taxation in the financing of the system, while assessment and administration takes place at the regional level and local taxes are levied to supplement LTC expenditure; last, public debate on LTC funding and organization was intense before the crisis with common concerns about cost containment of social care.

**Table 1 – Models of elderly care policies at the beginning of 1990s and in 2006: main reforms**

<b>Country</b>	<b>Welfare typology</b>	<b>Original model (80s-90s)</b>	<b>Revised model (90s-2006)</b>	<b>Reform introduced</b>
<b>France</b>	Conservative formal care	Mixed model; more informal care oriented	Mixed and integrated model	APA (2001)
<b>Italy</b>	Conservative family care	Informal care-led model	Informal care-led model	No national reform; only regional reforms
<b>UK</b>	Liberal informal care	Mixed model; more services oriented	Revised mixed model; more services oriented	Social Care Markets (1990) Direct Payments (1996)

Source: Casey et al, 2003, Esping Andersen, 1990, Bettio and Plattenga, 2004 retrieved from Rummery, 2009; Pavoline and Ranci, 2008

In France, discussion for a fifth risk on dependency has long been monopolizing public debate without a definite plan drafted before the burst of the credit crunch. In Italy, a country with less developed formal sector and largely dependent on informal care, policy debates focused on how to better regulate care provision and deal with the grey labour market and how to overcome inequalities between Italian regions. Worries about increasing private payments for care and the sustainability of National Dependency Fund which was established in 2007 were also addressed by stakeholders and academics. In the English system, social care is completely distinct from health care with the former being mainly means-tested while the latter is provided for free under the National Health Service (NHS). Here as well, local council undertake the responsibility of administering LTC provision with wide discretion on how to use the state grants. Debates on a sustainable model of LTC provision date back to 1999 when a Royal Commission was shaped to make recommendations on LTC.

All three states already have a type (or more) of cash benefits for care in place. The French Personal Autonomy Allowance (APA), is a universal benefit, financed both at regional and national levels, strictly controlled by the *departments*, mainly to be used for formal care provision. The Italian “indennità di accompagnamento” is funded through central taxation, while other types of benefits and services may be provided by regions, resulting in large inequalities in between geographic areas. The English system knows means-tested direct payments and allowances granted independently from the income of the care receiver as well as care allowance for carers. The details and the commonalities in between these cash payments will be discussed in the main part of this paper.

The aim of this paper is to find common concerns, trends but also differences in policy decision and implementation between the three welfare states that have a link with the financial and economic crisis. In particular, I will look into the following elements of cash-for-care schemes in the three countries:

1. Financing sources and organisation: How is LTC organised? what is the role of the national and the local level in administration, assessment of eligibility and level of benefit? What are the funding arrangements? Is there a separate dependency fund? Is LTC administered under the health care insurance? Is there a clear distinction between the health and social components of LTC and how are they treated differently from an organizational and funding point of view?...
2. Eligibility: Are cash benefits means-tested? Are conditions related to the level of disability/dependency and how are they defined (scales) ? Who is the recipient of the benefit (care user or caregiver) ? is there a discretionary power of the granting (local) authority and are there national guidelines? ...
3. Generosity of the benefit: What is the level of the benefits and what does it cover? Is co-payment envisaged? Does the amount depend on the level of disability/dependency? ...

4. Usage of the cash payment: Is there a state control? Can it be used in institutional setting or only for provision at home? Are there any restrictions for formal or informal provision of care? Can it be used to pay relatives of the care user? ...

This paper is structured as follows: first, I will make an overview of the LTC systems in the three countries pinpointing the above-mentioned aspects which are relevant to cash payments. After briefly elucidating how the economic crisis has evolved into a social crisis, I will look at the after-the-crisis pictures of the three welfare states making an assessment of how the world economic recession has affected cash-for-care schemes. The findings of my research will be presented per country and in relation to each other in the conclusion.

For the purposes of this research I looked into data provided by literature, primary sources, policy papers, newspaper and online articles, press releases, research projects findings even videos on policy debates found on the internet. In order to have a clearer picture of the national situation from 2000 onwards I have contacted academics, professionals but also lobby groups who work in this field. Without their contribution it would be very difficult to clarify which of the developments in the policy debate the last 10 years are the most relevant to my research.

As the recent Greek debt crisis has shown, developments are still ongoing, and it is unclear what the evolution of the crisis will be. In a topic as complex as measuring the impact of the crisis on social security systems, I believe, it is appropriate to use any available source of information and to be aware not only that it is highly impossible to reach exhaustive findings but that it is even likely that they will change soon after its completion.

## **CHAPTER 2 – STATE OF THE ART BEFORE THE CRISIS**

### **2.1. France**

As shown in Figure 2 old-age dependency ratio in France is below the average of EU27. However, according to INSEE's<sup>5</sup> estimations, if demographic tendencies continue, by 2050

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<sup>5</sup> Institut national de la statistique et des études économiques (National Institute of Statistics and Economic Studies)

about one out of three French inhabitants will be over 60 years old, while the same ratio in 2005 was one out of five. Moreover, on the 1<sup>st</sup> January 2050 for every 10 inhabitants belonging in the 20-59 age group there will be 7 persons over the age of 60. This would mean that the ratio would almost double in 45 years.

**Table 2 – Projection of the population (in % ) in 2050 (Metropolitan France)**

	<b>Population on 1<sup>st</sup> January (in millions)</b>	<b>Under 20 years old</b>	<b>20 - 59 age group</b>	<b>60 - 74 age group</b>	<b>Over 75 years old</b>
2015	63.7	24.0	51.4	15.5	9.1
2020	65.0	23.7	50.1	17.1	9.1
2025	66.1	23.1	49.0	17.4	10.5
2030	67.2	22.6	48.1	17.3	12.0
2035	68.2	22.2	47.2	17.3	13.3
2040	69.0	22.1	46.9	16.7	14.3
2045	69.6	22.0	46.4	16.6	15.0
2050	70.0	21.9	46.2	16.3	15.6

Source : INSEE, Projections de population 2005-2050

Under the current budgetary situation 1% of GDP (19 billions euros) is allocated to LTC<sup>6</sup>. By 2025 it is expected that LTC expenditure will reach 1.5% of GDP entailing major challenges for the French social security system.

### **2.1.1. Brief historic overview**

Until 1994 there was no specific policy for dependency planned in the French territory<sup>7</sup>. The first attempt to address the risk of dependency was adopting pilot schemes at the local level. In 1997 a temporary national scheme was approved with the introduction of the *Préstation Spécifique Dépendance* (PSD) which after severe criticism was replaced in 2002

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<sup>6</sup> Both social care and nursing services

<sup>7</sup> However for disabled people there existed the *Allocation compensatrice pour tierce personne* (ACTP) – meaning third person compensatory benefit

by the *Allocation Personnalisée d'Autonomie* (APA). The heat wave in 2003 which caused about 15.000 deaths among which the majority were elderly living alone was considered a turning point in national policy-making, resulting in setting LTC among the state priorities (LEDa-LEGOS, 2010). A year afterwards the *Caisse Nationale de Solidarité pour l'Autonomie* (CNSA) was established with the mandate to contribute to the financing of the risk of dependency but also to plan and coordinate LTC at the national level.

### 2.1.2. Characteristics of the French LTC system

Under the French system the part of LTC costs related to health/nursing care services either at home or in institutions are paid by health insurance. On the other hand, social care related to the risk of dependency (meaning costs outside the scope of health insurance) is covered by two separate schemes, one for dependent elderly and one for disabled people under the age of 60, namely the *Allocation Personnalisée d'Autonomie*<sup>8</sup> (APA) and the *Prestation de compensation du handicap*<sup>9</sup> (PCH) respectively. Meanwhile, it should be noted that France has a big market of private insurance for long-term care, ranking as the second in the world in this area after the United States (US).

In terms of financing, long-term care policy<sup>10</sup> is borne by the health insurance system (60%) and the départements (20%). The CNSA manages revenue collected through general taxation<sup>11</sup>: a fraction (0.1) of the *Contribution sociale généralisée*<sup>12</sup> (CSG), as well as the *Contribution Solidarité Autonomie*<sup>13</sup> (CSA). The state plans LTC policy but also intervenes through fiscal advantages, which are outside the scope of this study.

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<sup>8</sup> Personalised autonomy allowance

<sup>9</sup> Disability compensation benefit

<sup>10</sup> In total, meaning both health and social care aspects

<sup>11</sup> Representing about 15% of the total LTC expenditure

<sup>12</sup> General Social Contribution is in fact a tax used to finance social security expenditure

<sup>13</sup> Solidarity Contribution for Autonomy comes from the National Day for Solidarity which in principle is a day of unpaid work for which the employer pays a contribution of 0.3% of the payroll as contribution

### 2.1.3. Introduction of the APA

The PSD was introduced in 1997 not only as a means to deal with the growing costs of ageing and dependency but also envisaging to create a new job market and to cope with the caregivers deficit. It was a means-tested benefit delivered by the *Conseils Généraux*<sup>14</sup>, covering only the most dependent people (corresponding to the first three scales of the national scale for measuring dependency<sup>15</sup>). Beneficiaries were able to use it to fund long-term care services both at home and in institution and they were allowed to pay their relatives but not their spouses and partners. However, the PSD failed: first, because the number of potential beneficiaries was very limited as the benefit was dependent on income and not applied for average dependency. Second, it did not encourage the creation of new jobs but on the contrary it created job insecurity in the LTC sector<sup>16</sup>. Last, there were large inequalities between the French regions.

Thus, the APA came to replace the PSD with the aim to contain costs and increase the number of recipients. Unlike the previous scheme, the APA is a universal benefit for which anyone over the age of 60 can apply regardless of income. However, it has introduced a system of co-payment which varies according to the care user means, although under a certain threshold people do not pay user fees. Moreover, the new benefit is also allocated to people belonging in the fourth dependency scale, covering therefore also average dependency. Besides it does not include a provision for estate recovery.

The largest part of the APA is funded by the départements (through local taxes), while the CNSA distributes the revenue received through the CSA and the CSG trying to reach a balance by giving more to the départements with the largest deficits. In this sense, the APA is more efficient in combating the inequalities between regions.

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<sup>14</sup> General Councils

<sup>15</sup> In France the most common scale used is the AGGIR (*Autonomie Gérontologique – groupes iso-ressources*) assessing dependency from GIR-1 to GIR-6

<sup>16</sup> The main reason for this was that the scheme encouraged the option to acquire care through *services mandataires* instead of *services prestataires* (Martin and Le Bihan, 2007)

This cash benefit is in a fact a routed wage, provided to care users in order to pay for their care services. Although the care recipients can use the benefit to pay their relatives (with the exceptions under the PSD being retained here as well) the system is oriented towards professional care using case management and even organizing care services through non-profit organizations. In practice older persons claim the benefit from the *Conseils Généraux*, who are in charge of assessing the individual needs and propose the appropriate care package. Moreover, the local authorities monitor and evaluate the implementation of the personalized care plan.

In December 2009<sup>17</sup>, 1.136.000 dependent elderly received the APA benefit, with an increase of 1,9% since December 2008. Among the beneficiaries, 62% lived in their own homes and 38% in an institutional setting. The average amount of the care package for people living at home was 498 euros per month (1006 euro on average for the most dependant and 356 euros for the least dependant), with an average of around 122 euros paid by the care recipient as co-payment. (DREES, 2009)

Since 2001 public expenditure for APA is increasing, reaching in 2008 about 6 billions euros, among which about 4,5 was financed by local authorities.(Assemblée des départements de France, 2009) It seems therefore logical that one of the main issues to be addressed in the near future is how to finance APA as the *départements* are already struggling to allocate their scarce resources to fund the risk of dependency.

#### **2.1.4. A French specificity: the 60 years-old barrier<sup>18</sup>**

For the disabled under the age of 60, the *Prestation de compensation du handicap*<sup>19</sup> (PCH) came into force in January 2006, replacing the ACTP<sup>20</sup> although those who already

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<sup>17</sup> Numbers corresponding to Metropolitan France and overseas departments of France (DOM)

<sup>18</sup> This paragraph was based on the comments made by Ms. Geneviève Laroque, President of the Fondation Nationale de Gérontologie (France), who was kind enough to respond thoroughly to my questions

<sup>19</sup> Disability compensation benefit

<sup>20</sup> *Allocation compensatrice pour tierce personne*

received the ACTP could remain under the previous scheme. The rate of this allowance reached in June 2009 an average of 980 euros. This figure shows that in average the PCH is twice as generous as the APA benefit! Moreover, for the former benefit there is no *'ticket modérateur'*<sup>21</sup>, whereas the APA beneficiaries contribute to LTC costs from 0% to 90% depending on their income. Besides, the PCH uses a different grid<sup>22</sup> which is more analytical than the AGGIR scale.

Disparities in between the two schemes arise from the conceptualization of the notions dependency and disability as depicted in French law. In fact, French legislation considers dependency linked with old age as a predictable, if not inevitable, condition that the older person requires help and/or surveillance in everyday life<sup>23</sup>. On the other hand, disability is seen as a (unpredictable) limited capacity to act, due to which the person is entitled to compensation<sup>24</sup>.

According to article 13 of the law which introduced the PCH, the age barrier should be removed by the 1<sup>st</sup> January 2011. Although, planned reforms included proposals on converging the two benefits, as it will be shown in the next part of this paper, this is highly unlikely to happen for the moment mainly due to economic constraints.

### **2.1.5. The debate around the fifth risk**

In France discussions on a fifth risk<sup>25</sup> for social security date back (at least) to 2003 and the report by Jean Marie Palach<sup>26</sup>. The objective of the creation of new branch of social

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<sup>21</sup> User fee

<sup>22</sup> GEVA : Guide d' evaluation des besoins de compensation de la personne handicapée

<sup>23</sup> Loi du 24 janvier 1997 : *"La dépendance se dit de l'état de la personne qui, nonobstant les soins qu'elle est susceptible de recevoir, a besoin d'être aidée pour l'accomplissement des actes essentiels de la vie ou requiert une surveillance régulière"*

<sup>24</sup> Loi du 11 février 2005 : *"Constitue un handicap toute limitation d'activité ou restriction de participation à la vie en société subie dans son environnement par une personne en raison d'une altération substantielle, durable ou définitive d'une ou plusieurs fonctions physiques, sensorielles, mentales, cognitives ou psychiques, d'un polyhandicap ou d'un trouble de santé invalidant"*

<sup>25</sup> The four traditional risks recognized under the French social security system are: sickness, family, work accidents and old-age (pensions)

security is to allocate to the disabled and to the frail elderly a ‘personalized help’ for autonomy in kind or in cash. The instauration of the fifth risk would mean granting a universal right to compensation regardless of the age of the care recipient. Several issues have become the focus of public debate on the fifth risk: 1) removing the age barrier which discriminates between those under and those over 60 years old, 2) finding a sustainable model of funding the risk of dependency, 3) putting in place a new system of governance for the fifth risk.

The French President announced at the end of 2007 that a bill concerning the creation of a fifth social insurance branch would be proposed to the Parliament in early 2008. As it will be shown later, the debate on the fifth risk has been largely affected by the crisis which hit hard public finances.

## **2.2. Italy**

According to ISTAT<sup>27</sup>, 2.615.000 Italians are in need of LTC, among which 2 millions are over 65 years old. (ISTAT, 2008) Italy is the European country with the highest share of people over 80, in relation to the working population (Figure 2). In 2007 over 25% of the Italian population was over 65 years old. The same year total public LTC expenditure reached around 25.8 billion euros (1.66% of GDP), among which costs for the *indennità di accompagnamento*, a cash benefit provided by the *Istituto Nazionale della Previdenza Sociale*<sup>28</sup> (INPS), amounted to 10.8 billion euros. Given this rapid ageing process, *non auto-sufficienza* (non self-sufficiency) is often in the centre of public debate.

### **2.2.1. General context of care provision in Italy**

The Italian LTC system knows three forms of assistance: community care; residential care and cash benefits. Health and social care services both at home and in institutions are managed by local authorities, mainly by municipalities. After a Constitutional amendment in 2001, regional governments have competence to legislate on this field as well as

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<sup>26</sup> Palach, J. (2003), *Vieillesse et solidarités*. La Documentation française

<sup>27</sup> Istituto nazionale di statistica (National Institut of Statistics)

<sup>28</sup> National Social Security Institute

arranging LTC services. However, the State is responsible for defining minimum standards across the country in order to guarantee that needs are met without great disparities between regions. Still the so called *Livelli Essenziali di Prestazioni* (LEP) have not yet been established, therefore wide differences between regions continue to exist with a great gap noticed between the North and the South of the country. As organization and funding of LTC is largely fragmented, some authors consider appropriate to speak about various regional LTC systems rather than a national scheme. (ISAE, 2009)

Italy has traditionally relied on informal provision of care mainly through the extended family. However, due to demographic trends and changes in the family structure, the availability of family support has become scarce, posing additional challenges to public policy.

Although official data on the level of private payments for LTC are lacking, it is estimated that individuals assume almost half of the total cost and more than 37% of the population over 60 rely on some kind of private assistance. (Network Non Autosufficienza, 2009; CENSIS-ASSR, 2004) As public services are meagre, Italian older people tend to stay at home cared for by foreign unskilled workers, (the so-called *badante*) employed in the grey market.

In terms both of expenditure and population coverage, the *indennità di accompagnamento* represents the most important means of support of dependent elderly in Italy. (Gori and Da Roit, 2007) The evolution of this benefit is quite remarkable representing today more than 90% of the allocations targeting the 65+ population, with around 70% of the recipients being older women. According to the latest available data, 9.5% of persons aged 65 years and over received the cash benefit in 2008. This percentage increases from 2.1% of persons aged 65-69 years, to 5.3% of those aged 70-79 years, up to 23.8% of those aged 80 years and over. (ISAE, 2009)

### **2.2.2. Overview of the *indennità di accompagnamento***

Introduced in 1980 the *indennità di accompagnamento* was initially conceived to compensate the loss of income due to incapacity for work. Thus, in the beginning, only the

active population was eligible for this benefit and not until 1988 was it applied to people over the age of 65.

The creation of the *indennità di accompagnamento* was consistent with the Italian welfare regime characterized by underdeveloped public services and a clear preference for cash benefits. Given that care in Italy is perceived as a private issue, cash payments are granted as an alternative to residential care and are considered the most appropriate policy measure enabling users to have a say on their care while compensating at the same time the large amount of care provided in the household of the care recipient. A clear advantage of this system is that it does not create a need for public care provision. (Gori and Da Roit, 2007)

The *indennità di accompagnamento* is granted by the INPS to all people in need of care regardless of age and economic situation. According to national legislation recipients must be 100% disabled (i.e. cannot walk without help or need assistance in carrying out activities of daily life) and not admitted in residential care homes for free. It is run at a national scale and funded through general taxation, although claimants have to apply to local authorities who are competent for making a decision on eligibility. There is no control of how the benefit is used; the amount therefore passes into the family budget and in practice can be used to cover expenses even outside the field of care. The monthly rate of this benefit is set annually and what differentiates Italy from other countries on this aspect, is that the amount granted is independent both from the means of the care user but also from the level of dependency. Another peculiarity of the Italian scheme is that beneficiaries are not given the option to choose between a cash benefit and a public service; distinct assessment procedures create discontinuity between the available services and their integration under one system impossible. (Network Non Autosufficienza, 2009)

### **2.2.3. Locally funded cash benefits**

Cash benefits provided by municipalities and regions are widespread in the Centre-North of the country but not so much in the South. Although there is an important geographic variation, in general terms, local allowances for care are both means and needs-tested targeting people with high levels of dependency and low income. In contrary to the national

dependency allowance (*indennità di accompagnamento*), these benefits are often provided with a care plan, the implementation of which is closely monitored. These payments are financed through local funds and are meant to keep people at home, enabling beneficiaries to use them to pay relatives. As expected, procedures of application and assessment as well as amounts vary from one area to another. In practice these benefits may overcome some of the shortcomings of the national scheme and make up for the absence of public services. (Gori and Da Roit, 2007)

**Table 3 – Cash benefits funded and provided at local level (Italy)**

Region or Province	Name & Year of introduction	% of over 65 population receiving the benefit	Average monthly rate (in euros)
Provincia di Bolzano	Assegno di ospedalizzazione (2007)	3 – 4 %	515
Veneto	Assegno di cura (2007)	2, 2 %	200
Emilia Romagna	Assegno di cura anziani (2006)	1, 9 %	246
Liguria	Misura economica del Fondo regionale per la non autosufficienza (2008)	1, 6 %	330
Friuli – Venezia Giulia	Assegno per l'autonomia (APA) (2007)	1 %	375
Lombardia	Buono sociale (2006)	0,9%	-
Provincia di Trento	Sussidio per la cura domiciliare di un anziano non autosufficiente (2006)	0,6 %	354
Umbria	Assegno di cura (2005)	0,4 %	418
Toscana	ADI indiretta (2006)	0,3 %	-
Piemonte	Assegno di cura (2006)	0,2 %	-
Abruzzo, Calabria, Sicilia	Measure introduced in 2003 in Sicilia and Calabria and in 2006 in Abruzzo	<0,3 %	-

Source: Network Non Autosufficienza, 2009

#### 2.2.4. Incremental reforms

Besides some changes at the local level, the Italian LTC system is characterized by strong inertia. Since the 1990s it has not undergone any major reform, with the exception of the establishment of the National Dependency Fund in 2007. Thanks to this fund for the first time Italian regions were granted state resources to be used explicitly in the field of LTC. The objective was to avoid fragmentation and create incentives for the creation of funds at the regional level. The amounts allocated to this fund were 100 million euros for the first year and 300 and 400 million euros for the following two years (2008 and 2009). There is wide concern among stakeholders about the future of this fund. Although in October 2009 its continuation for 2010 was confirmed with the allocation of 400 million euros<sup>29</sup>, currently it seems to be absent from every budgetary projection. Will the Dependency Fund be one of the victims of austerity plans in Italy?

It should perhaps be noted that back in 1997, the Onofri Commission<sup>30</sup> set up to evaluate social spending, recommended the creation of a national fund that would pool the resources allocated for the *indennità di accompagnamento*. This fund would provide the revenue necessary for payments for care and services. On the contrary, under the current system the distinction between the national dependency allowance and the local provision of services was maintained.

Nowadays, the debate touching upon cash benefits for care is centered around monitoring the use of the *indennità di accompagnamento* to ensure that it is used to fund LTC expenditure; reorganizing the system so that the national dependency allowance becomes a part of the local care system, which would allow a better use of resources; establishing clear criteria for the allocation of the benefits and differentiating the amount depending on the level of dependency; overcoming regional differences.

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<sup>29</sup> This was agreed with New Health Pact 2010 – 2012, signed on October 12<sup>th</sup> 2009 (ISAE, 2009)

<sup>30</sup> Commissione per l'analisi per le compatibilità macroeconomiche della spesa sociale, 1997

### **2.3. England**

In comparison to Italy and France, the ageing process in the UK is not as alarming, since as it is illustrated in figure 2, it counts among the “younger countries” of the EU. This however does not imply that the old-age dependency in the UK does not gradually increase; it only means that it does so at a relatively slower pace than in other European countries. According to the projections of the Office for National Statistics, the number of people aged 85 plus, will more than double by 2033, reaching 3.2 million inhabitants. Currently the majority in this age-group are older women who live alone at home and receive some kind of formal or informal care<sup>31</sup>.

In 2006 total LTC expenditure for older people in England amounted to just under 20 billion euros, out of which 20.6% was funded by the NHS, 39.7% by local authorities and 39.7% by individuals and their families as user fees or private payments. (Wittenberg et al, 2008) The rising numbers of old people will prompt a new settlement focusing on ‘community care’ (home care), personalized care services and support for the carers.

#### **2.3.1. Brief overview of the English LTC system**

The English system distinguishes between the health and social components of LTC, including the former in the NHS, while for the latter a safety net mechanism for people with low income and assets is provided. Health services are funded by central taxation and insurance contributions while the primary providers of social care are local councils, which finance LTC expenditure via state grants and local taxes. Individual contribution for LTC costs is significant, taking the form either of co-payments or private purchase of services in the market.

Older people apply for public care services at the local level and after a needs assessment, a package of services or a cash benefit is defined and allocated to the user. However, variations among the different regions are widespread.

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<sup>31</sup> According to the PSSRU macro model in 2006 out of 550.000 older people with a severe disability, around 400.000 were women (Wittenberg et al, 2008)

### **2.3.2. Overlapping cash payments**

Although the direct payments scheme was introduced in 1996 with the Community Care (Direct Payments) Act, it only opened its doors to older people in 2000. In the beginning it was conceived as a cash payment for disabled people until the age of 65, giving the option to care recipients to manage their own care instead of using the community services. The development of this benefits owes a lot to the ‘independent living’ movement as strong lobbying for the empowerment of disabled people has gradually changed the perception of LTC, putting the accent to the choice of the care user. Cash-for-care was thus seen as a tool to enable care users to control their care, which was considered beneficial for the care recipients as it allowed them to seek care tailored to their individual needs and expectations. Meanwhile, a study by the British Council of Organizations of disabled People on the cost-efficiency of cash benefits in comparison with traditional care services, provided the impetus for its adoption. (Ungerson and Yeandle, 2007b)

Under the direct payment scheme disabled and older people are able to apply for payments instead of services as long as they fulfil the needs and means assessment. Local authorities enjoy a large discretion on the matter; in practice eligibility criteria and rates vary a lot in between regions as the idea is that the local councils are in charge of meeting the needs of their population depending on their financial capacities. Still, a national eligibility framework describing four levels (low, moderate, substantial and critical) of need for care exists. Although, the objective of this tool was to ensure that people with similar needs would receive similar outcomes, local authorities are free to chose where to set the threshold within those bands, making therefore disparities in access to the system very common, while there are concerns that coverage of people with average needs is insufficient. (PSSRU, 2010)

The scheme is financed by non ear-marked state grants, supplemented by revenue from local taxes. The amount that the care recipient is entitled to is defined by the local authority and is dependent on the need for care in reference to the cost of care should it be provided in kind. The cash payments are supposed to be used to employ formal carers, with a regulatory system aiming to monitor that care is provided in consistency with the UK

employment law and that the benefit is not used within the household of the care user. The main disbarment of the English system is that, unlike the Italian system, older people cannot pay directly family members and people sharing the same household. Moreover, it cannot be used to buy services from the local authority while guidance in the recruitment of carers is minimal. These count among the main reasons for low take-up rates which make direct payments of little practical importance as in 2004 less than 1% of the population aged over 65 was able to receive them. (Pavoline and Ranci, 2008) A recent report<sup>32</sup> by the Commission for Social Care Inspection made a number of recommendations for the improvement the operation of eligibility criteria, asking for a clearer, simpler, framework and for the development of a national formula for determining individual budgets, in order to increase transparency and make it easier for people to take their assessment from one local authority to another.

In parallel to the direct payments scheme which is run by the local councils on a budget-constraint basis, another benefit provided at a national scale exists. The attendance allowance is non means-tested and its rate depends on whether the individual needs help and supervision during day and/or night. In England more than £3 billion is spent on Attendance Allowance, corresponding to around half as much as is spent on social care for older people by councils. (Caring Choices coalition, 2008)

This benefit aims to meet care needs but in practice it operates as a compensation for disability, as there is no control on how it is used. There are concerns that the majority of the recipients of this benefit do not use it to cover care needs, neither at an informal nor at a formal setting. Another advantage of this scheme (besides the absence of a means-test) is that it operates on a national basis and there are not disparities in between regions. However, discussions on how to align the two benefits and allocate resources more efficiently are currently taking place. (Humphries et al, 2010)

In addition, the Disability Living Allowance targeting people under the age of 65,

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<sup>32</sup> Commission for Social Care Inspection (2008), *Cutting the Cake Fairly: CSCI review of eligibility criteria for social care*

continues to be provided to beneficiaries once they have reached the age of 65. This benefit will not be examined in details in this paper.

The English system provides financial support to carers, granting them the Carer's Allowance. Conditions for the receipt of this means-tested benefit are also set nationally and include: providing informal care to a person receiving a cash payment for care (i.e. Attendance Allowance) for more than 35 hours per week and not being enrolled in full-time education. The low level of this benefit (£53.90 per week) qualifies it more as a sort of compensation for the loss of income rather than a routed wage for informal care. In addition to this, carers may apply for the Carer Premium<sup>33</sup> which is not a benefit but an extra amount of money included in the calculation of other benefits.

Apparently, all these benefits have some overlapping functions, it is thus not strange that different stakeholders argue for a better coordination, or even integration, of the different systems. An attempt to bring together some of the concurring entitlements of the care user is described below.

### **2.3.3. A pilot project aiming to improve choice on care**

The idea for a scheme including individual budgets with the objective to facilitate user involvement in the care planning, to control how needs are met as well as to focus on user-defined outcomes was included in the Green Paper on Social Care published in 2005. In the same year a pilot project involving 13 local authorities was launched and ran from November 2005 to December 2007. (Glendinning et al, 2008)

The 'Individual budgets' (IB) programme aimed to integrate different funding streams and offer greater flexibility to the care users. The objective was to pool these resources together and support users in the planning of their care. As the English system is far from an

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<sup>33</sup> The Carer Premium is not a benefit but an extra amount of money included in the calculation of Income Support, income-based Job seekers' Allowance, Housing Benefit and Council Tax Benefit. An equivalent amount is used in the calculation of Pension Credit. (Carers UK)

integrated model, with fragmented services varying widely in the country, bringing together resources as different as disability benefits and community equipment services was quite a challenge. It must however be noted that attendance allowances and NHS funding did not become part of this pilot scheme.

Despite the difficulties in implementation, the scheme received a positive evaluation. IBs were considered a cost-effective solution in comparison with conventional social care. Moreover, the conditions for their usage being less restrictive than the ones applied for direct payments, allowed users to choose among a wider variety of services, including to pay relatives for care. The majority of the participants used the benefit to finance personal care, assistance with domestic chores, and social, leisure and educational activities. However, older people felt that the process of planning for their care constituted an additional burden. This project has demonstrated that a balance between responding to individual needs and safeguarding vulnerable adults needs to be struck. Moreover, a number of issues have to be clarified before moving on to a national implementation. Thus, a national debate on under which model (principles and procedure) resources should be allocated is deemed indispensable. (Glendinning et al, 2008)

#### **2.3.4. Recent policy debate**

Since 1999 and the establishment of the Royal Commission on LTC, there has been a wide debate on the future of care in England. As it will be shown in the next paragraphs, the main axes of this debate are:

- how to fund future LTC expenditure?
- how to help care users plan their care needs?
- how to support informal care?

The report by the Royal Commission<sup>34</sup> recommended that personal care needs should be met by the State through general taxation without a means-test procedure. However, at the

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<sup>34</sup> Royal Commission on Long Term Care (1999) *With respect to old age: Rights and Responsibilities*

end of the day the government rejected on grounds of costs this proposal and only accepted the abolition of the means-test condition for nursing care at an institutional setting in England. Thus, until today the majority of cash benefits and public services are still means-tested.

A report issued by the King's Fund<sup>35</sup> in 2006 has been very influential in shaping views about the LTC sector in England. The Wanless social care review showed the stress on long-term care provision and concluded with a funding proposal focusing on a shared responsibility between State and individuals. According to this model a package of basic care should be provided for free without a means-test and topped up by personal contributions matched by the state. The review argued that this system would have the advantage of meeting people's needs more efficiently while at the same time creating incentives for savings to fund long-term care expenditure. The report estimated that the extra cost of this model would be between £1.7 billion and £4.2 billion per year, depending on whether some of the resources spent on the Attendance Allowance and Disability Living Allowance were redirected to the social care system<sup>36</sup>. (Wanless 2006)

After the 2005 Green Paper on Social Care, entitled *Independence, Well-being and Choice*, another government initiative expressed the vision to transform the delivery of social care. The ministerial concordat *Putting People First* included objectives for a universal information, advice and advocacy service, and a common assessment framework. Besides, the key implication of this consultation was putting the accent to personalised care support.

A civil society coalition named '*Caring Choices*' has undertaken a nationwide initiative to help shape future policy on long-term care for older people. In 2008 the report *Who will pay for long term care?* argued for a universal scheme funded by state and individuals and promoted the establishment of nationally agreed eligibility criteria.

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<sup>35</sup> Wanless D. (2006), *Securing Good Care for Older People: Taking a long-term view*

<sup>36</sup> As explained above, these two benefits do not constitute a part of the social care system which is run by local authorities

In 2009 the government proposed a fundamental reform of the care system in England building a new National Care Service. Although the funding and organisational arrangements are far from sorted at the moment this is high on the political agenda.

**Table 4 – Landmarks in LTC policy debate (England)**

Year	Who	Initiative	Main Recommendations
1999	Royal Commission on LTC	Report of the Royal Commission on LTC	State-funded LTC model; personal care for free; accomodation costs paid only by wealthier recipients
2005	Department of Health	Independence, Well-being and Choice: Our vision for the future of social care for adults in England (Green Paper on Social Care)	Enhance individual choice and control of care user; individual budgets
2006	The King's fund	Securing Good Care for Older People: Taking a long-term view, The Wanless social care review	Restricting means-testing for personal care and putting in place a free package of basic care, topped up by personal contributions matched by the state
2007	Ministers, local government, NHS, social care, professional and regulatory organisations	Putting people first: a shared vision and commitment to the transformation of adult social care (Ministerial Concordat)	Collaboration between central and local government, the sector's professional leadership, providers and the regulator; aims and values which will guide the transformation of adult social care; a new delivery model based on personalization
2008	Caring Choices coalition	Who will pay for long term care?	Non means-tested system funded by the state with co-payments by individuals ; nationally agreed eligibility criteria
2009	Department of Health	Green Paper : Shaping the Future of Care Together	Government's vision for a National Care Service; Consultation for the future of LTC
2010 March	The King's Fund	Securing Good Care for More People: Options for Reform	3 funding options : the existing system with no reform; free personal care; state funds 50% of everyone's care and support costs, and matches every £2 contributed by the individual with a further £1
2010 March	Department of Health	White Paper: Building a National Care Service	Buiding the National Care Service in stages : Personal Care at Home Bill (2011) ; free care extended to institutions (2014) ; free care for all eligible adults funded by contributions (after 2015)
2010 May	Coalition Government	The Coalition : Our programme for Government	Establishment of a Commission on LTC; extension of personal budgets; support to carers through direct payments

## CHAPTER 3 - THE SOCIAL COMPONENT OF THE CRISIS

What was in the beginning the subprime mortgage crisis in the US, very soon transformed in the deepest recession that hit global economy since the post-war history. Public debt in the euro area is projected to reach 100% of GDP by 2014 and is expected to impact the economy long beyond the current forecast horizon. (European Commission, 2009a) The recession has had a major impact on public finances, with the government deficit in the EU reaching 7¼% of GDP this year and projected to improve slightly in 2011. (European Commission, 2010)

In the social security field the crisis translated into diminishing the pool of financial resources (due to falling revenues from contributions and taxes) while the number of potential beneficiaries rose. Indeed, according to an ISSA<sup>37</sup> survey, social security revenue has decreased significantly because contributions, investment income, government subsidies and social security reserves have reduced. In addition, social security expenditure is growing due to increased demand for benefits for unemployment, housing, social assistance and health care. (ISSA, 2009)

As a result, due to the deterioration of public finances there may be a reduction in the level of funding LTC which together with demographic ageing pose major policy challenges to social security systems. The current budgetary situation also entails cutbacks from local authorities who are among the main providers and funders of LTC.

### 3.1. An opportunity for change?

The word “crisis” comes from the Greek verb “κρίνω” which means to decide, to choose, to evaluate. In the Greek sense of the word, “crisis” refers to a definitive, irrevocable decision among alternative key options. In this perspective, the current crisis does not have only a negative facade; it also represents an opportunity for change. States are asked to take policy decisions which may influence the development of social security systems.

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<sup>37</sup> International Social Security Association

The Social Security Act of 1935 that introduced “social security” in the United States is connected with the economic crisis of the 1930s. Moreover in the UK, the Beverigdean social security reform was implemented during the post-war period, while currently in the US, under the pressure of the economic crisis, health care for all is in the limelight. (Bonnet et al, 2010) Will the current crisis act as a stimulus for social reforms in the EU?

### **3.2. The EU response**

Under the exceptional circumstances of the financial distress the EU launched the European Economic Recovery Plan in December 2008, recommending the use of buffer measures to help the households most affected by the crisis. (European Commission, 2008b) Social protection was asked to play an important role in the recovery process while the European Commission and the Social Protection Committee encouraged the introduction of different social measures, in particular regarding the labour market; maintaining household income; reducing the impact of the crisis on households; investing in social and health infrastructures. (Council of the European Union, 2009) In 2009, the Commission has issued a Communication on the long-term sustainability of public finances for a recovering economy, proposing what the stance of the Member States under the current economic turmoil should be.

With regard to Italy and France the Commission estimates that the long-term costs of ageing will not be particularly high, but taking into consideration their initial budgetary position, fiscal consolidation is deemed essential to improve sustainability and reduce debt ratios. As far as the UK is concerned, the Commission envisages a higher long-term risk, but also a danger of fast increase in debt ratios in the medium run. Thus, it calls both for ambitious consolidation programmes that reduce debts and deficits and profound reforms of social protection. (European Commission, 2009b)

It is perhaps too early for safe conclusions on how and whether these recommendations will be put in practice in the short and medium perspective. However, in the wake of Greece's debt crisis, several European countries have already announced austerity measures : the UK has decided a plan for immediate cuts of 6.2 billion pounds, while Italy has in recent weeks

approved a bill to reduce the budget deficit by 24 billion euros over two years. For the moment, France has not yet adopted an austerity plan but reducing unnecessary expenditure is clearly among the state priorities.

For the authors of *Social Security in times of Crisis*<sup>38</sup>, States are faced with the possibility either to expand or to contract their social security systems. The Greek crisis has perhaps demonstrated that the EU and the international organizations are in favour of limited public spending, encouraging cuts in social security expenditure as a condition to receive financial support. Will other States follow this model or will they try to contain costs avoiding any major challenges in the social security system? How did France, Italy and England react to the current crisis? How do they plan to finance the increased expenditure needs in the long-term care sector? What will the balance between public and private provision be after the crisis? What will happen to planned reforms? Although acknowledging that at a time when it is unclear how deep the crisis is and for how long it will go on it is impossible to search for exhaustive answers, the following paragraphs of this paper explore some of the impacts of the crisis on the organization and funding of cash-for-care.

### **3.3. France**

The crisis has clearly had an impact on the financing of social protection programmes in France. The *Projet de loi de financement de la sécurité sociale 2010*<sup>39</sup> (PFLSS 2010) acknowledges a collapse of social security revenues and rising deficits in 2009 and 2010 due to the crisis. In fact, the government estimates that the crisis has largely contributed to the deterioration of the financial accounts as for the first time since the end of World War II, there is a recess in wage income for two years in a row, leading in a total loss for social

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<sup>38</sup> Bonnet, F., Ehmke, E. and Hagemeyer, K. (2010), *Social security in times of crisis*, International Social Security Review, Vol. 63, 2/2010

<sup>39</sup> Bill on the financing of social security for 2010

security (in 2009 and 2010) of 21 billion euros. The “crisis deficit” represents approximately 65% of the deficit in 2009 and 75% of the deficit in 2010<sup>40</sup>.

For the time being, the government has announced that there is no intention to increase contribution rates or taxes to finance social security, neither to make significant cutbacks in social security expenditure. (Palier et al, 2010)

Regarding LTC, as the wages and the income from capital which constitute the bases for the two *contributions* that finance the risk of dependency have reduced, the revenues of the CNSA have also lowered considerably. Concretely, while the income from these *contributions* reached 1,95 billion euros in 2005 and increased gradually until 2008 attaining a total of 2,29 billion, in 2009 they faced a diminution of 3,9% (corresponding to a total of 2,21 billion euros). According to the *Assemblée des Départements de France* (ADF) as an after-effect of the crisis there was a cut down of around 120 million euros on the revenue allocated by the CNSA to the *départements*.<sup>41</sup> As the *départements* already bear more than 2/3 of the total financing of the APA<sup>42</sup>, this fall of income entailed a financial and social hardship for regional authorities who can no longer support it.

In January 2010 the ADF has presented to the French Prime Minister a memorandum showing (among others) the difficulties faced by the local authorities in financing the cash benefits for care<sup>43</sup>. In fact, in 2008 expenditure for the APA reached 4,85 billions euros while the annual deficit for this benefit struck more than 3,2 billion euros. Recently the *département* of Saône and Loire, being among the first ones to sound the alarm for the serious financial uncertainty faced by local authorities, has declared its decision to raise

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<sup>40</sup> Data retrieved from <http://www.gouvernement.fr/gouvernement/financement-de-la-securite-sociale-pour-2010>

<sup>41</sup> Assemblée des Départements de France (2009), Communiqué de Presse. Personnes âgées, personnes handicapées: nouveau désengagement de l’Etat, issued on the 1st April 2009, found in [www.departement.org](http://www.departement.org)

<sup>42</sup> It should be noted that initially it was planned that the *départements* and the CNSA would contribute equally to the financing of the cash payments for care

<sup>43</sup> Assemblée des Départements de France (2010), Mémorandum en faveur des départements en difficulté. Présenté à Monsieur François Fillon, Premier Ministre

local taxes by 15% in order to invest in residential homes for the elderly and finance the APA.

The budgetary constraints faced by the *départements* has induced an urgent call for a sustainable model for financing the cash benefits for dependency, growing the conflict between the State and the local level.

Under the exceptional circumstances created by the crisis, an obvious question is raised: how to put in place a fifth branch of social security while the social security system is in deficit?

As previously stated, in 2007 the French President has expressed his engagement for a separate social insurance for the risk of dependency. In its 2007 annual report the CNSA proposed a tripartite funding arrangement for the new branch: regional and national taxation (referred to as national solidarity); private insurance; and family income, underlining that the means of the care user should be taken into consideration. Meanwhile, in May 2008 the government announced a reform which (among others) would give to the wealthier beneficiaries of the APA benefit (with an annual income of over 200.000 euros) the option to receive a reduced benefit or to apply for an estate recovery and get the full-rate allowance. Moreover, a senatorial mission was set up for the proposed scheme which published its report (Vasselle report) in July 2008<sup>44</sup>. From this point on, I believe, the impact of the crisis is apparent in every upcoming report and political discourse.

### **3.3.1. The convergence between APA and PCH stays out of the debate**

In fact, in contradiction with the initial plan to bring the APA and the PCH benefits together under one scheme, but also in contradiction with article 13 of the law of the 11th February 2005 on the PCH and European treaties who prohibit disparities in social and health care benefits based on age, the Vasselle rapport abandons this idea. The obvious reason for this change of stance is lack of financial resources. According to the above-

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<sup>44</sup> Vasselle A. (2008), *Rapport d'information fait au nom de la mission commune d'information sur la prise en charge de la dépendance et la création d'un cinquième risque*, Sénat, n°447, Annexe au Procès verbal de la session du 8 juillet 2008

mentioned report around 8 billions euros are needed to align the two benefits. The same report has put forward the concept of estate recovery as a means to finance LTC and encouraged the take-up of private insurance.

### **3.3.2. The road for the private sector is now open**

In the aftermath of the economic crisis, public discourse on removing the responsibility for dependency from the public pillar to private insurance gains territory. Xavier Darcos, talking on the 10th March 2010 on the occasion of the 5th annual conference of *Les Echos* has outlined the future of the risk of dependency as follows: national solidarity should remain the main pillar; family support should be strengthened, possibly through an enhanced role assumed by individual wealth; individual and collective insurance should be encouraged. The minister added that technical cooperation was launched between insurers and two working groups were set up by the Government with the objective to improve the evaluation grids and to define the content of the insurance contracts (waiting time, transferability and other conditions). He clarified that the ultimate goal of the government is to provide French citizens with transparent, good quality supplementary insurance by *mutuelles*, *assurances* and *institutions de prévoyance*.

As it seems impossible to provide national support that would cover 100% of the costs and of the potential beneficiaries, a public-private partnership seems to have reached a consensus among the stakeholders. Even public opinion seems more ready to accept this proposal<sup>45</sup>, although there arguments against an obligatory supplementary private scheme.<sup>46</sup>

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<sup>45</sup> In the article, *Du "cinquième risque" à la "solidarité pour l'autonomie"* published in *Le Monde Economie* on the 15<sup>th</sup> February 2010 (accessible on line via: [http://www.lemonde.fr/economie/article/2010/02/15/du-cinquieme-risque-a-la-solidarite-pour-l-autonomie\\_1305877\\_3234.html](http://www.lemonde.fr/economie/article/2010/02/15/du-cinquieme-risque-a-la-solidarite-pour-l-autonomie_1305877_3234.html) ) a survey by La Banque Postale-TNS Sofres published by *La Tribune* shows that for 45% of the French population the risk of dependency should be assumed by the State only for the poorest segment of the population.

<sup>46</sup> Ennuyer, B. (2010), *Vers un nouveau champ de protection sociale pour le maintien de l'autonomie et la participation à la vie sociale des personnes en situation de handicap, quelque soit leur âge. Quelques éléments du débat en cours, début 2010*, Collectif « Une société pour tous les âges » « 5ème risque »- *Éléments du débat*, <http://une-societe-pour->

Of course it must not be neglected that France already has a large market in the LTC insurance field. However, what remains to be seen is whether the crisis has paved the way for the private sector and whether in the future the French system will be oriented towards a safety-net mechanism complemented by obligatory private insurance.

### **3.3.3. A new postponement for the bill on dependency**

The adoption of the bill for the fifth risk has been deferred several times. Although, in January 2010 the French President has reconfirmed his engagement that the new branch of social security counted among the major projects for 2010, a month later during the meeting for the social agenda 2010 it was announced that this issue would not be tackled before the conclusion of the pension reform. In practice this leaves little time for the submission of the text on the fifth risk before the end of 2010, which leads to a new postponement until 2011. This has been reaffirmed by the Secretary of the State for Seniors, on the 26th May. However, the debate still continues and some clarifications may be made before this date.

Despite the fact that the main characteristics of the system seem to have reached a consensus (financing of the system through national solidarity and insurance companies and the retainment of the option for estate recovery), the debate is not yet concluded. Remains to be decided what the level of contribution of each of the three actors will be and whether there will be complementary “players” in the final plan.

The Jamet report on the budgetary situation of the *départements*, indubitably affected by the crisis, concluded that the abolition of the clause on estate recovery in the APA legislation has deteriorated the situation. The rapporteur proposes to establish a minimum threshold which would be complemented by an amount allocated under the condition

that the care users would engage a part of their assets. Thus, the Jamet report is not far from the proposal made by the Vasselle report. (Jamet, 2010)

The ADF has repeatedly urged the increase of the contribution by the CNSA for the APA, by doubling the rate of 0.1% currently applied to the CSG. In the *Mémoire* it is explained that this measure would enable to reach the 50% of the financing of this benefit by the CNSA which was the initial agreement at the adoption of the APA benefit.

Other proposals on the table of negotiations include: a social contribution throughout the whole active life and after retirement age; a tax on inheritances and donations; and a second solidarity day.

But for Bernard Ennuyer<sup>47</sup>, it is a question of political choice and not of financing. The sociologist explains that according to the *Cours de Comptes* there would be 75 billions euros from non-levied taxes, whereas the funding of the dependency would need only 7,5 billions euros.

Then there is the question of the management of this new risk: in case it is entrusted to the CNSA, what will the relation between the CNSA and the départements be? How will expenditure be monitored? Will users associations have a say in the new system of governance? (Ennuyer, 2010) Due to the postponement of the bill these questions still remain unanswered.

### 3.4. Italy

In Italy considerable budget cuts for the period 2010-2012 were already decided with Law 133/2008. When decree-law 185/2008 was converted into law 2/2009 1,3 billion euros less than initially estimated were allocated to public expenditure<sup>48</sup>. The social part of this

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<sup>47</sup>Cinquième risque, (2010) *Pour Bernard Ennuyer, le financement du cinquième risque dépend d'un choix politique*, published on April 14, 2010, [www.cinquieme-risque.fr/pour-bernard-ennuyer-le-financement-du-cinquieme-risque-depend-dun-choix-politique/](http://www.cinquieme-risque.fr/pour-bernard-ennuyer-le-financement-du-cinquieme-risque-depend-dun-choix-politique/)

<sup>48</sup> “The decree originally envisaged a total expenditure of EUR 6.3 billion; but - once the decree was converted into law - the figure dropped to EUR 5 billion” (Fargion, 2009)

legislation focused on family benefits and unemployment, leaving little space for changes in the LTC sector.

### **3.4.1. The implications of fiscal federalism**

A recent delegation law<sup>49</sup> has devolved financial competence in the social field from the state to the regions. The so-called ‘fiscal federalism’ means that regional authorities are entirely competent for funding health, social care and education. Given that state grants were eliminated, the role of the national level limits itself to guaranteeing that a minimum level of services is accomplished in all geographic parts of Italy. This should be implemented through the legal adoption of the *Livelli Essenziali di Prestazioni* (LEP) which would also define necessary relative costs. A uniform application of these standards would overcome arbitrary allocation of resources, striking a better balance between regions and attaining financial stability.

Despite this redistribution of competences, the LEP have not yet been established, leading to a kind of ‘lame’ federalism that creates new responsibilities without really changing the scenery. It is probable that the stark deterioration of public finances impedes any development towards the adoption of these standards that would overcome the large inequalities between regions.

### **3.4.2. Increased number of controls**

Another important development in 2009 was the implementation of an extraordinary plan of inspections to verify that the beneficiaries of the *indennità di accompagnamento* actually met the eligibility criteria. (Ministero della salute, 2008) Out of the 200.000 controls carried out it was discovered that 15% of the recipients were not eligible for this benefit. (Gori, 2010) Although this measure clearly envisaged decreasing the number of beneficiaries and consequently cutting social expenditure, it was decided before the crisis and thus was not a direct consequence of it. It is however interesting to note that the government is planning to go on with these controls as the so-called *falsi invalidi* (fake

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<sup>49</sup> Legge-Delega 42/2009

disabled) are often in the focus of public attention. It is highly probable that the current decline in public revenues will provide an additional stimulus to enhance the monitoring of the *indennità di accompagnamento*.

### 3.4.3. The adoption of *la manovra*

With public debt reaching 118,2% of GDP<sup>50</sup> in 2010, in the past weeks the Italian government has adopted a new decree-law<sup>51</sup> focusing on urgent measures for financial stabilization and economic competitiveness. The so-called *manovra* aims to bring the ratio of Italian debt in 2012 to below 3% of GDP, projecting to save 24 billion euros during the next 2 years.

Despite concerns about imposing an income ceiling which would make the *indennità di accompagnamento* means-tested, the final draft of this decree-law did not contain such a provision. The inclusion of this clause in the bill had caused great opposition by interest groups in the disability sector, pledging for radical changes in the field of social care. It appears however that public debt, forced to a soaring level under the pressure caused by the crisis, will continue to act as an obstacle to a comprehensive social reform.

### 3.5. England

For Prof. Glennerster, even before the recession, UK public finances suffered from a structural deficit; over the past decade governments have grown social spending by 5% while national revenue has not increased. Following this policy by 2060 would mean increasing welfare expenditure between 6 and 10% of GDP. (Glennerster, 2010)

The UK has entered the crisis with a public deficit of 2,5% of GDP; currently, it amounts to 12% of GDP. This number being the highest in the EU (even larger than Greece) a cut in funding for social care seems likely in the UK. Alternatively, the newly elected government would have to find unpopular ways to finance the costs of an ageing population.

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<sup>50</sup> European Commission (2010), Directorate-General for Economic and Financial Affairs, *Commission Staff Working Document, European Economic Forecast, Spring 2010*

<sup>51</sup> Decreto-legge di 31 maggio 2010, No.78

Social care in England is undergoing a transition period. The need for reform was acknowledged back in 2007, after the publication of the King's Fund report. At that time, the government decided to undertake a consultation and explore different options for reform. However, the current difficult fiscal climate proves that while the need for fundamental changes is greater than ever, the timing could not be worse. (Humphries et al, 2010) With a sharp decline in public finances the last two years, finding a sustainable solution to the financing of LTC becomes an even bigger challenge. It is perhaps too early to tell with certainty how far policy-makers will go and exactly how reforms will be shaped.

### **3.5.1. Towards a National Care Service**

While policy-making is directed towards a person-centred model of care, the state of public finances seems bleak. In 2009 the long-awaited *Green Paper Shaping the Future of Care Together* was published. This paper presented the (previous) government's vision on the future of LTC, resuming some of the ideas found in the King's Fund report of 2006: the partnership model, the distinction between accommodation and personal care costs and the integration of the Attendance Allowance in the social care mix.

In 2009 the Labour party pledged for free personal care at home, while the Conservatives advanced the idea of a voluntary insurance scheme that would cover residential expenses through a premium on retirement amounting to around £8,000.

In March 2010 the last government launched a White Paper aiming to build a free National Care Service (NCS) for all after 2015. As its name suggests, this comprehensive scheme would run alongside the NHS, providing free care when people need it. Under the NCS, people in need of care would be granted a personal budget that they would be able to use either to buy care on the market, or pay their relatives, or use the services provided by their community. As a meso-phase the Labour government was planning to provide free residential care to all people after two years of residency by 2014.

In the proposal for the NCS some elements already apparent in previous proposals are easily recognizable: the system would be universal and free; ensuring choice and control; recognizing contribution of informal carers giving care users the option to pay family

members for care. The decision on how this system would be funded was deferred until after the elections.

For the time being the government of coalition has announced its commitment to search for possibilities to fund the NCS, establishing a Commission on the matter. What the implications of a potential different set of priorities will be, remains to be seen.

### **3.5.2. Funding options**

The Labour party was clearly in favour of a system of compulsory contributions, although what exact form these would take was unclear. The possibility to defer pensions, pay an amount up front or deduce a sum from the individual's estate after death were equally considered. On the other hand, the Conservatives pledged for a voluntary levy and accused the (former) government of wanting to impose a death tax of 10% on all estates to pay for the national care service.

In 2008 the International Longevity Centre proposed the creation of a National Care Fund, which would be a voluntary state insurance scheme. In order to be entitled to a care package, individuals would pay a single means-tested contribution, which could also be obtained from the estate of the care user after death. (Lloyd, 2008)

A recent report by the King's Fund<sup>52</sup> examined three possibilities: continuing with the existing system, free personal care and a revised partnership model<sup>53</sup> under which the state would cover 50% of the care expenditure and match every £2 contributed by the individual with a further £1. In this proposal, the authors have explicitly taken into consideration the current economic climate, diminishing the part of the care package assumed by the state and using a ratio of 2 for 1 instead of 1 for 1 for the top up. The report concluded that the a shared responsibility model was at the same time faire and relatively affordable.

Other proposals in the basket of policy options include freezing on inheritance tax allowances and efficiency savings within the NHS and a complementary private insurance

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<sup>52</sup> Humphries et al (2010), *Securing good care for more people. Options for reform*, The King's Fund

<sup>53</sup> The first version of this model was developed in the 2006 report (Wanless, 2006)

approved by the State.

The soaring levels of public deficit apparently cast a shadow over the future of public spending for LTC, obliging stakeholders to think that money should be found elsewhere.

## CHAPTER 4 - CONCLUSION

After an overview of the *before and after* pictures of the LTC systems, it is quite clear that there were no radical changes in the post-crisis period. Nevertheless, a comparison of the three different countries, allows for some general remarks to be made.

### 4.1. Same but different: the ‘care mix’ matters

For the scope of this paper I have studied three countries that although are intrinsically different, they also share some common points. Lacking, a public social insurance scheme for LTC, Italy, France and England have developed a system of allocation of cash benefits for care. As we have seen, different reasons lie behind the development of these benefits: for France it was the objective to create a new labour market; in England as a result of strong lobbying by the disability movement granting power to the individual merited special policy attention; in Italy the idea behind the *indennità di accompagnamento* was to provide supplementary resources to the bleak budgets of families with dependent members. In addition England and Italy seem to be driven first by concerns for affordable solutions, as services are in general more expensive than cash payments. On the other hand, when investing on professional care France was seeking a sustainable model that could face the shortage of family carers.

Of course all these circumstances have broad implications for policy making. Whereas in England the introduction of cash benefits is closely linked with the ideal of control and choice on care by the care user, in Italy, albeit not insignificant, it appears that this is not the main reason for a strong state preference for cash benefits. Indeed, it could be argued that cash payments underpin the lack of activity in the formal care provision, providing an excuse for not looking for caring agencies outside the Italian family. In practice, this is also demonstrated by the current extremely loose system of control of the *indennità di accompagnamento*. On the contrary, France encourages formal care provision, also in a

semi-public (not-for-profit) setting. The French tool of assessment is indubitably more sophisticated than the criteria of the Italian system which know no scales of dependency. Most importantly, the allocation of the APA benefit is strongly linked with a care plan whose implementation is closely monitored. In this sense, the French APA is conceived as a routed wage for formal carers whereas the Italian benefit is a simple allowance used to complement family revenue. The English system is somewhere in between, as it defines some national eligibility criteria although implementation varies from one area to the other. Meanwhile, given that the attendance allowance is not controlled, it has a similar function to the *indennità di accompagnamento*; on the other hand direct payments are regulated although they fail to provide users with a care package.

With the exception of France where public services and the APA are aligned, although not completely integrated, the other two countries make a clear distinction between social care services and cash payments. In fact in France, provision of formal care is partly managed by the *départements*. As we have seen, in Italy public services are largely underdeveloped and fragmented. The national dependency allowance in practice can rarely be combined with a network of public services. Moreover, the two distinct levels – national for the *indennità di accompagnamento* and local for social care services – make it harder to achieve a fair and efficient allocation of resources. The situation is not so different in England where, despite the fact that the management and funding of both care services and direct payments are the responsibility of the local councils, the cash benefit is hardly ever used to pay for public services. Without doubt, instead of encouraging institutional care, all three systems emphasize in one way or another a turn to community care, mainly providing financial support for informal and formal care at home.

Of course the way systems are funded and operated is also very relevant to the ‘care mix’ as the choice *national versus local* financing and governance can have an impact on the outcomes of cash-for-care schemes. Hence, in England local councils enjoy a large margin of appreciation leading to a different assessment of needs and rates of benefits in the various regions. As far as the *indennità di accompagnamento* and the APA are concerned, there are fixed amounts and uniform criteria across the two countries. However, in the case

of Italy, disparities between regions arise due to the fact that assessment of eligibility takes place at the local level and mainly because of the lack of national standards. Therefore depending on place of residency, Italian older people may or may not receive a supplementary local cash benefit (whose generosity also varies) and may or may not have access to public services for care. In France, large inequalities in different parts of the country, although probably not inexistent, are not a principal concern at the moment.

It is also noteworthy that with regard to the national scheme, Italian regions do not have co-financing responsibilities; in fact, as already demonstrated, it is as if several local systems co-exist in parallel with the *indennità di accompagnamento*. This characteristic gives a quite different dynamic in domestic politics, in comparison with France and England where local authorities bear a large part of the funding of the cash benefits for care. As a result, the local level in these two countries is largely implicated in the debate on cash-for-care given that the powers delegated to them by the State are often in conflict with their capacities and local needs.

Another important distinction is the nature of the systems: whereas the French and the Italian benefits are universal, England has a safety-net orientation. Indeed with the exception of the attendance allowances, English benefits and services are means-tested. This remark becomes particularly relevant as we try to define whether the three systems at a time of political and economical uncertainty are taking a different direction.

Moreover, it should be noted that at the onset of the crisis the three studied countries were firstly facing similar challenges and secondly, they were engaged in debates about social security reform. As we have seen in the introduction, demographic ageing and changes in family created a rise in spending demands and prompted intense and sustained action in the field of LTC. Moreover, as France, Italy and England were tackling large budget deficits, affordable solutions were the main concern. However at the time of the economic downturn the three countries did not have an equally developed LTC system, neither were debates on reforms taking place to the same extent.

In Italy the national cash scheme introduced in the 1980s has not been revised ever since; it is thus hard to imagine how this allowance could respond to the needs of modern societies and economies. But the Italian LTC is largely described as inert. To this point considerations about a comprehensive reform in Italy were more at a theoretical level. On the contrary in France the debate on LTC seemed more mature. It gained a lot of public attention and discussions on a potential social insurance were concrete although exact arrangements were still missing. Similarly, English public opinion unpicked the complexities of a fundamental change in the LTC sector. The main issues on the table of negotiations of the three countries - although not identical - deal with a better allocation of resources and creating sustainable models that are at the same time 'user-friendly'.

#### **4.2. Lessons from the crisis**

The decline in public revenue has inevitably weakened the capacity of social security systems to confront future challenges, such as the rising numbers of the elderly. As tax income decreased with recession, escalating risks for financial solidity and sustainability of social security systems made their appearance throughout Europe. European decision-makers are now asked to make sacrifices, imposing restrictions and freezing public outlays in order to be in tune with budget-cutbacks in other parts of Europe.

With incurring operational deficits Italy, England and France were confronted with important decisions in order to deal with the increased pressure on public revenue. France has explicitly decided not to undertake any significant cuts in social security expenditure neither to impose new levels of taxes. On the other hand, UK and Italy have recently announced a set of austerity measures. Indubitably, these decisions entail a political cost, therefore governments are hesitating to take several stark measures in the name of a robust economy.

Notwithstanding, in comparison to the traditional social risks, people have a different attitude towards the contingency of dependency. For now, in countries like France, Italy and England where there is no insurance scheme based on contributions, it is impossible to talk about acquired rights in the field of LTC. Moreover, as trade unions play little or no

role in social planning, it is likely that organisations and funding arrangements may change more easily. Social opposition in this area is not expressed in the same way as in the field of pensions for example. Indeed, it is hard to imagine thousands of people striking for a reform in the LTC sector. Of course this does not mean that there is no pressure imposed on government initiatives. Experts, lobby groups, care professionals, family but also pensioners organisations often lament the lack of comprehensive changes in care and they attract a lot of public attention. Nevertheless, this particularity may make it harder for LTC to find its place among the clamour of competing priorities in the national scene.

#### **4.2.1. Delayed policy action**

The EU has clearly put an emphasis on protecting the vulnerable as a part of the exit strategy from the crisis. Unemployment benefits and social assistance for low-income households are particularly encouraged. Pension systems, suffering greatly from limited contributions due to unemployment and the alarming ratio between active and inactive population, will prompt immediate measures. It appears that the pressure for social security systems comes from multiple sources.

In the light of the current difficult economic climate, European states are asked to make choices and to prioritize their agendas. France has explicitly announced a delay at least until 2011 for the long-awaited bill on dependency. The government has decided to tackle first pension reform and deal with LTC at a later stage. Family allowances and unemployment benefits clearly underpin the Italian post-crisis social policy as demonstrated with the adoption of law 2/2009. Still there is no reform for LTC underway, with the only positive sign being the non inclusion of the means test for the national dependency benefit in the *manovra*. However, for the moment it is very unclear how the government will act on this field should further cost-containment measures be needed. In England the new government has inherited the last government's 'unfinished business' on the construction of a National Care Service. Although, the Conservative-Liberal coalition has confirmed that a reform of the LTC scheme is high on their agenda, there are no indications on when this will take place. For the moment, a Commission is supposed to be

established that will make recommendations on the matter.

Perhaps it is not appropriate to talk about a *trend* to postpone LTC reforms, but what recent history has shown is that under the pressure of the crisis, when it comes to making choices about the timeframe of reforms, decision-makers tend to put LTC in second place. Especially in the case of England and France where concrete plans were on the rails, it seems that recession made it even harder to reach a consensus on funding and organization of the new risk unless some other issues are resolved first. Nevertheless, one must not think that planned changes were cancelled as a result of the crisis. States will have eventually to deal with this issue, as the common challenges identified in the introduction will require concrete responses. However, a concrete ‘victim’ was identified in France; against the backdrop of cost-containment the convergence of the two French benefits, that would result in a fair treatment of the elderly and the disabled people seems very unlikely to take place. Given that it’s too early to measure the actual impact of the crisis, it is uncertain at the moment what the future arrangements will be, although some orientations could be identified.

#### **4.2.2. The future of cash-for-care**

One thing that seems not to be affected by the crisis is the role that cash benefits play in the field of LTC. Indeed, it appears that although the economic downturn has changed the context under which reforms should take place, cash-for-care schemes were not threatened. In general terms, the findings did not show a tendency to reduce cash payments or to replace them by public services. Nonetheless in Italy the crisis may prove to be the driving force for a better control of the system of allocation of the *indennità di accompagnamento*. Other than that, in debates there is a trend urging for an integration of the various cash benefits as well as care services to reach more efficient and fairer solutions.

Hence, the crisis has underlined that cash benefits as an alternative to services are here to stay. The obvious reason for this is that, as it was shown already before the crisis, cash benefits are a cost-effective way to address the risk of dependency. Moreover, they allow care users to seek care in the market thus limiting the need for public care provision,

boosting jobs in the care sector and enhancing competition. Cash payments are very much in line with increased public expectations for care and allow a greater degree of choice which is important in today's consumerist society. Perhaps the future of cash-for-care is personal budgets which enable older people some control and purchasing power. At the same time these individual budgets should be accompanied by a care plan which would facilitate appropriate care decisions, encourage take-up and monitor abuse. The UK government coalition has explicitly stated its intention to move towards this direction<sup>54</sup>.

#### **4.2.3. In search of new funding models**

The deterioration of public finances has made evident that the risk of dependency cannot be based on a public pillar alone. Policy developments in the studied countries include numerous proposals for the financing of LTC, among which there seems to be a consensus about a share of responsibilities between the state and the individual as well as a significant role assumed by the private sector.

The crisis has made clear that the upcoming reforms will not take the burden off the families who already bear a large share of the costs for LTC, either through co-payments or providing unpaid care for relatives. The proposed arrangements are very much focused on individual or family wealth. For policy-makers it is logical that users pay (at least) for a part of their care. Although there are no final decisions about the form this would take, the latest considerations include: contributions to a private or semi-private LTC fund; private long-term care insurance; estate recovery; lump-sum paid upfront in a public scheme; prolongation of retirement age and use of pension to finance LTC and others. This means that LTC is not considered a risk meriting to be assumed by the society as a whole but on the contrary as an individual risk. Whether this should be financed by voluntary or compulsory costs is also uncertain. Therefore a model based on intergenerational solidarity does not seem to have reached wide acceptance.

Moreover, as older people are asked to give up a part of their wealth to pay for LTC, first,

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<sup>54</sup> HM Government (2010b), *The Coalition: our programme for government*

the duty of the family to finance LTC needs of the dependent member is eased down and second, the possibility for younger members to become owners of the capital owned by their older relatives is eliminated. Hence, these proposals are likely to have an impact on family arrangements and family solidarity as well.

Evidently, this enables a part of the funding of LTC to be delegated to the private sector. The question now is what role will the state play in this development. Will it encourage voluntary insurance or will it take the road of compulsory complementary private insurance? Will it intervene to guarantee fair contracts and design the new schemes? These questions are particularly pertinent for France, but other European states are likely to face similar challenges in the near future.

#### **4.2.4. An enhanced role for local authorities**

Social care has traditionally been provided at the local level. Meanwhile, some of the cash-benefits studied run at a national scale but are operated locally. The role of local authorities is therefore particularly important for LTC. Without doubt, even before the crisis States entrusted a large part of LTC provision to regions and municipalities. This model is not likely to change in the future. The recently introduced fiscal federalism in Italy is just one of the examples that the government makes an effort to transfer responsibility. In France we have seen the state contributing less and less to the financing of APA, leaving therefore the départements to cope with the increasing costs. Not surprisingly in England the situation is quite similar with stakeholders pledging for an comprehensive local care system.

Without neglecting the advantages of this model, which encourages care at the local level meaning closer to the care recipient, experts and civil society advocate that in order to mitigate the risk of unmet needs, the state must take an active role, through financing agreements, imposing national standards, making regular controls etc.

#### **4.2.5. Towards safety-net mechanisms?**

It is probably too early to tell whether due to the severe cuts in public spending, states will adopt safety-net mechanisms. This kind of proposals are already discussed in the studied countries so a final text fixing a tax-funded benefit for low income claimants and

promoting private insurance for the rest of the population should not come as a surprise. Such a development would have a great impact on the LTC sector as the number of beneficiaries would shrink down, forcing families to face alone the costs of LTC at a time when the crisis has largely affected individual income as well. Probably it depends on whether the first set of measures taken by European states will be sufficient and efficient in curing more than the symptoms of the recession.

#### **4.3. Concluding remarks**

Since 2000 LTC systems in Italy, France and England have known very few reforms. This paper has pinpointed policy thinking in this field before and after the crisis. Unsurprisingly, the findings showed that the crisis has not dramatically changed the scenery for dependency. It has however provided orientations for the future arrangements for funding and organizing cash-for-care, mainly through eliminating some of the proposals, rather than bringing new ideas on the table. Moreover, instead of accelerating decision-making, it has led to a postponement of the final decisions. Although for the moment the degree of coverage does not seem to have been significantly affected, questions are raised about whether schemes will take up a safety-net function in the end. Perhaps the most important finding referred to the demarcation of responsibilities between the public and private sphere. Indeed, recession has confirmed that social security systems cannot afford to have a sheer tax-funded public pillar for LTC, given that they already face escalating operational deficits.

### ANNEX – Overview of cash payments for care (France, Italy and England)

Country	Name	Eligibility	Assessment tools	Benefit rates	Funding	Implementation	Usage of benefits
<b>France</b>	Allocation Personnalisée d'Autonomie (APA)	*needs- tested *over 60 years *co-sharing depends on means	AGGIR grid (6 levels) assessed at local level	Maximum rates in April 2010 (in euros/month) *exemption from user fee for income less than 695, 70 <u>GIR1</u> : 1235,65 <u>GIR2</u> : 1059,13 <u>GIR3</u> : 794,35 <u>GIR4</u> : 529,56	Mainly local taxes plus CSG & CSA	Local (Conseils Généraux); strictly regulated	Depending on personalized care package defined by professionals; Both for home and institutional care; both for formal and informal care (spouses and partners excluded); carers employed directly or through agency
<b>Italy</b>	Indennità di accompagnamento	*severely disabled people (100%) regardless of age *needs-tested *regardless of financial means *not admitted for free in a care institution	Criteria defined by national legislation	Rate for 2010: 480, 47 euros/month	General taxation	Assessment by local health authorities	No care package; no control on usage; can be used to buy care in the market or to pay informal carer, including relatives without exemptions
<b>England</b>	Direct payments	*needs-tested *means-tested	National framework for eligibility criteria 'Fair Access to Care Eligibility Bands' (4 levels)	Determined locally depending on needs assessment and financial capacity of local authority	Central government grants and local taxes	Eligibility criteria, arrangements for assessments and budgetary arrangements determined locally	Carers employed directly but compliance with employment law required; need to keep record of expenses; close relatives and people sharing same household cannot be paid
	Attendance allowance	*over 65 years *in need of help for more than 6 months or terminally-ill	In need of help or supervision throughout the day or night or both <sup>55</sup>	In April 2010: *Rates depend on kind of help needed Higher rate -	General taxation	Administered at national level	No control of whether care is actually received

<sup>55</sup> Frequent attention throughout the day in connection with bodily functions

**Or** continual supervision throughout the day in order to avoid substantial danger to oneself or to others

**Or** prolonged or repeated attention during the night in connection with bodily functions

**Or** to be watched over for much of the night

		*non means-tested		£71.40/week. Lower rate - £47.80/week.			
	Carer's allowance	*care for a highly dependent person receiving a cash benefit for care *min. 35h/ week of care *over 16 years old *not in full-time education (21h/week) *means-tested (less than 100£/week)		£53.90/week (2010-2011 rate)	General taxation	Administered at national level	-

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